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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **WILLIAM JOHN DUKE** **3173 Neal Avenue, Apat. 1** **San Jose, CA 95117** **Registered Nurse License No. RN 602447** Respondent.	Case No. 2010-438 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about July 23, 2002, the Board issued Registered Nurse License Number 602447 to William John Duke ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2010, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an

inactive license, for any reason provided in Article 3 (commencing Code with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. Code section 4060 states, in pertinent part:

> No person shall possess any controlled substances, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor....

8. Health and Safety Code section 11173, subdivision (a) provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

REGULATORY PROVISIONS

9. California Code of Regulations, title 16, section ("Regulation") 1442 states:

> As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

10. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

11. **CONTROLLED SUBSTANCES**

"Hydromorphone", also known as "Dilaudid," is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K) and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Lorazepam" is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (d)(11) and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Lortab" is a Schedule III controlled substance as designated by Health and Safety Code Section 11056, subdivision (e)(4) and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Methadone Hydrochloride" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(14) and a dangerous drug pursuant to Code section 4022 in that under federal or state law it requires a prescription.

"Morphine" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M) and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Percocet", a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

"Vicodin" is a compound consisting of 5 mg hydrocodone bitartrate also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and 500 mg acetaminophen per tablet and a dangerous drug under Code section 4022 in that under federal or state law it requires a prescription.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a)(1) on the grounds of unprofessional conduct, in that between April and October 2006, while on duty as a registered nurse at San Ramon Regional Medical Center, San Ramon, California, Respondent committed acts constituting gross negligence, as defined in California Code of Regulations, section 1442, more particularly set forth in paragraphs 13, and 14, below.

SECOND CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances in Violation of Law)

13. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a) on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between in or about April and October 2006, Respondent committed the following acts:

a. Respondent obtain the controlled substances Hydromorphone, Lorazepam, Lortab, Methadone, Morphine, Percocet and Vicodin by fraud, deceit, misrepresentation or subterfuge by taking the drugs from hospital supplies in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed the controlled substances Hydromorphone, Lorazepam, Lortab, Methadone, Morphine, Percocet, and Vicodin without lawful authority in violation of Code section 4060.

THIRD CAUSE FOR DISCIPLINE

(Falsified or Made Grossly Incorrect, or Inconsistent Entries in Patient/Hospital Records)

14. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined by Code section 2762, subdivision (e), in that between in or about April and October 2006, while on duty as a registered nurse at San Ramon Medical Center, San Ramon, California, Respondent falsified or made grossly incorrect, grossly inconsistent or unintelligible entries in the following patient and/or hospital records:

Patient #1

a. On September 1, 2006, at 1324 hours, Respondent withdrew 10 mg of Morphine and at 1613 hours, Respondent removed 15 ml of Lortab from the Omnicell System[1] for this patient. Respondent documented the administration of 2 mg of Morphine and a 1/2 tsp of Lortab in the patient's Medication Administration Record; however, Respondent failed to chart the wastage or administration of any portion of the remaining Morphine or Lortab in the patient's Medication Administration Record or otherwise account for the disposition of the remaining drugs in any hospital record.

Patient #2

b. On April 30, 2006, at 2004 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient; however, Respondent failed to document the wastage or administration of any portion of the Hydromorphone on the patient's Medication Administration Record or otherwise account for the disposition of the drug in any patient or hospital record.

Patient #3

c. On September 9, 2006, at 1406 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient. Respondent documented the administration of 2 mg of Hydromorphone in the patient's Medication Administration Record; however, Respondent failed

[1] The Omnicell System is an automated medication dispensing system for the management and dispensing of medications at the point of use.

to document the wastage or administration or otherwise account for the disposition of the remaining 2 mg of Hydromorphone in any patient or hospital record. Further, Respondent charted the administration of 40 mg of Methadone at 1315 hours and 1500 hours; however, there is no documentation to show that Respondent withdrew the Methadone from the Omnicell Sytem.

Patient #4

d. On October 7, 2006, at 1935 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient. Respondent documented the administration of 2 mg of Hydromorphone in the patient's Medication Administration Record; however, Respondent failed to document the wastage or administration or otherwise account for the disposition of the remaining 2 mg of Hydromorphone in any patient or hospital record.

Patient #5

e. On October 26, 2006, at 1918 hours, Respondent withdrew 4 mg of Morphine from the Omnicell System for this patient. Respondent documented the administration of 1 mg of Morphine in the patient's Medication Administration Record; however, Respondent failed to document the wastage or administration or otherwise account for the disposition of the remaining 3 mg of Morphine in any patient or hospital record.

Patient #6

f. On October 15, 2006, at 0048 hours, Respondent withdrew 4 Vicodin tablets from the Omnicell System for this patient. Respondent failed to document the administration of the Vicodin in the patient's Medication Administration Record; however, a pharmacy label affixed to the procedure notes that indicated the Vicodin was given to the patient.

Patient #7

g. On September 25, 2006, at 2032 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient; however, Respondent failed to document the wastage or administration of any portion of the Hydromorphone in the patient's Medication Administration Record or otherwise account for the disposition of the drug in any patient or hospital record.

Patient #8

h. On September 22, 2006, at 1417 and 1555 hours, Respondent withdrew 4 mg of Hydromorphone, each time, from the Omnicell System for this patient. Respondent documented the administration of 1 mg of Hydromorphone, each time at 1438 and 1610 hours in the patient's Medication Administration Record; however, Respondent failed to document the wastage or administration or otherwise account for the disposition of the remaining 6 mg of Hydromorphone in any patient or hospital record.

Patient #9

i. On September 1, 2006, at 2235 hours, Respondent withdrew 1 mg tablet of Lorazepam from the Omnicell System for this patient; however, there was no physician's order for Lorazepam for this patient. Respondent documented the administration of a 1 mg tablet of Lorazepam at 2230 hours in the patient's Medication Administration Record.

Patient #10

j. On September 22, 2006, at 1612 hours, Respondent withdrew 2 mg of Hydromorphone from the Omnicell System for this patient. Respondent documented the administration of 1 mg of Hydromorphone in the patient's Medication Administration Record; however, Respondent failed to document the wastage or administration or otherwise account for the disposition of the remaining 1 mg of Hydromorphone in any patient or hospital record.

Patient #11

k. On September 3, 2006, at 2031 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient. Respondent documented the administration of 1 mg and the wastage of 2 mg of Hydromorphone in the patient's Medication Administration Record; however, Respondent failed to document the wastage or administration or otherwise account for the disposition of the remaining 1 mg of Hydromorphone in any patient or hospital record.

l. On September 3, 2006, at 2150 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient. Respondent documented the administration of 2 mg of Hydromorphone at 2158 hours and the administration of 1 mg at 2315 hours in the patient's Medication Administration Record; however, Respondent failed to document the wastage or

administration or otherwise account for the disposition of the remaining 1 mg of Hydromorphone in any patient or hospital record.

Patient #12

m. On September 1, 2006, at 2105 hours, Respondent withdrew 4 mg of Hydromorphone from the Omnicell System for this patient; however, Respondent was not assigned to this patient. Respondent failed to document the wastage or administration or otherwise account for the disposition of the Hydromorphone in any patient or hospital record.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

15. Respondent is subject to disciplinary action pursuant to Code section 2761, subdivision (a), in that Respondent committed acts constituting unprofessional conduct, as more particularly set forth in paragraphs 12, 13, and 14, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number RN 602447, issued to William John Duke.

2. Ordering William John Duke to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/17/10

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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